







PHOTO: WHO Representative, Dr Bardan Jung Rana, at the closing remarks of the Coordination Workshop on Additional Financing for Health Sector Support where progress reports on World Bank funded projects were presented by government representatives, UN agencies and other partners.

HIGHLIGHTS

- Under the leadership of the Government of Bangladesh (GoB), WHO Immunization and Vaccine Development (IVD) team, together with all humanitarian organizations responding to the Rohingya crisis, initiated a draft proposal and budget to include the refugee population in the National Deployment and Vaccination Plan for COVID-19 Vaccines (NDVP).
- A new reporting tool on data collection has been developed to strengthen coordination and collaboration between health actors across the camps. This new reporting tool will support the Health Sector and its stakeholders to enhance strategic decision-making, while showcasing the current status of utilization of the health services.
- The Health Sector coordination team organized a referral workshop in partnership with IOM and UNHCR to discuss pertinent challenges in referring patients including management of associated expenses.
- The IPC Technical Working Group arranged a meeting on the formation of the District IPC committee for Cox's Bazar envisioning improved patient and healthcare workforce safety.
- **SUBJECT IN FOCUS:** Facilitating equitable access to safe and effective COVID-19 vaccines: the inclusion of the Rohingya refugees in the Bangladesh COVID-19 national vaccination plan.

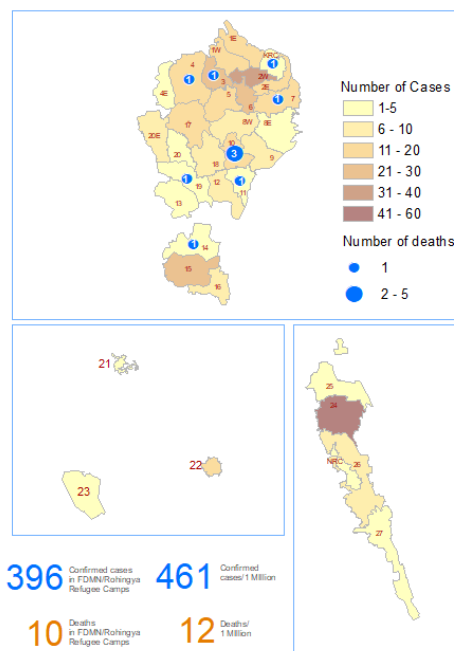
	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	5 538	396
 Total cases in isolation in Cox's Bazar	16	10
 Total number of tests conducted	58 219	28 958
 Total deaths due to COVID-19	73	10

WHO, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC) continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the COVID-19 emergency. During the reporting period, a total of eighteen (18) camp level Health Sector coordination meetings were held at Ukhiya and Teknaf Upazilas.

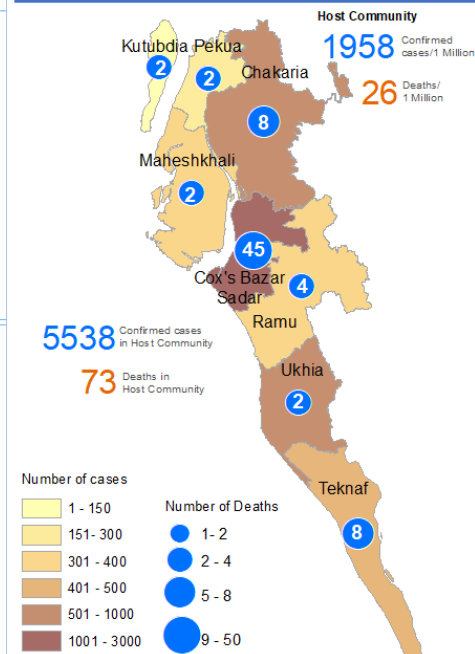
A new reporting tool on data collection has been developed to strengthen coordination and collaboration between health actors across the camps. This new reporting tool will support the Health Sector and its stakeholders to enhance strategic decision-making, while showcasing the current status of the health services. During the reporting period, data officers from over thirty (30) health agencies - including national and international NGOs - attended hands-on training on 4Ws report provided by the Health Sector. Supported by WHO and IOM, Health Sector renovated a meeting hall of Teknaf Upazila Health Complex. In addition, WHO and UNICEF supported the refurbishment work of the Blood Transfusion units at Ukhiya and Teknaf Health complexes, and the decoration of the neonatal stabilization unit. Both facilities were inaugurated with the presence of the Secretary of Ministry of Health and Family Welfare (MoHFW), the Deputy Representative of WHO and officials from IOM and UNICEF.

On February 9th, the Health Sector coordination team organized a referral workshop in partnership with IOM and UNHCR to discuss pertinent challenges in referring patients including management of associated expenses. Subsequent action points related to limiting barriers of referral and increasing efficiency were agreed for further implementation. Monitoring results from the third quarter of 2020 were discussed among camp health focal points for further dissemination to improve data collection among partners and camp authorities. Monitoring activities are expected to start shortly for the next quarter.

COVID-19 Cases in Rohingya Camps (As of 14 February 2021)



COVID-19 Cases in Cox's Bazar District (As of 14 February 2021)



SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION

WHO continues to provide epidemiological data to support operational decision making for the COVID-19 response in Cox's Bazar. As of 14 February 2021, a total of 5538 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 539 in Chokoria, 105 in Kutubdia, 361 in Maheshkhali, 221 in Pekua, 396 in Ramu, 2886 in Sadar, 457 in Teknaf and 573 in Ukhiya.

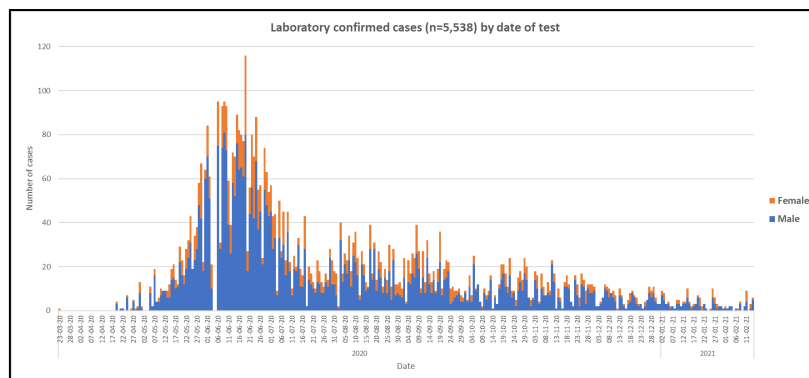


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

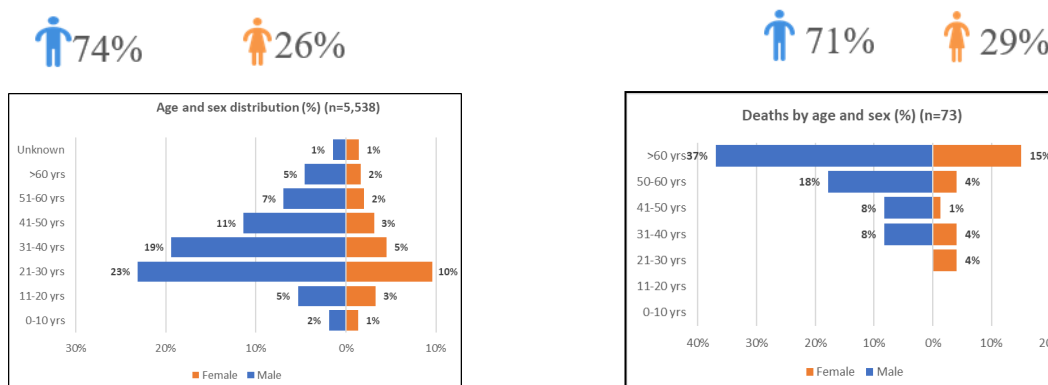


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

As of 14 February 2021, a total of 396 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 56 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 39 and Camps 3 and 15 with 29 and 26 cases, respectively. To date, 25 cases were reported from Camp 6, twenty from Camp 2E and 17 from Camp 4. Camps 1W and 5 had 14 and 13 cases respectively and camp 7 twelve cases to date. Camps 1E, Camp 10 and 22 registered 11 cases each. As for Camps 9, 18, 20 Ext and 26 nine cases were reported to date; and eight cases from Camp 16. Camps 12 and 8W registered 7 cases each. Camps 11, 19, and Nayapara RC identified 5 cases. The remainder Camps (Kutupalong RC, 4 Extension, 8E, 14, 20, 21, 23, 25 and 27) had so far less than 5 cases.

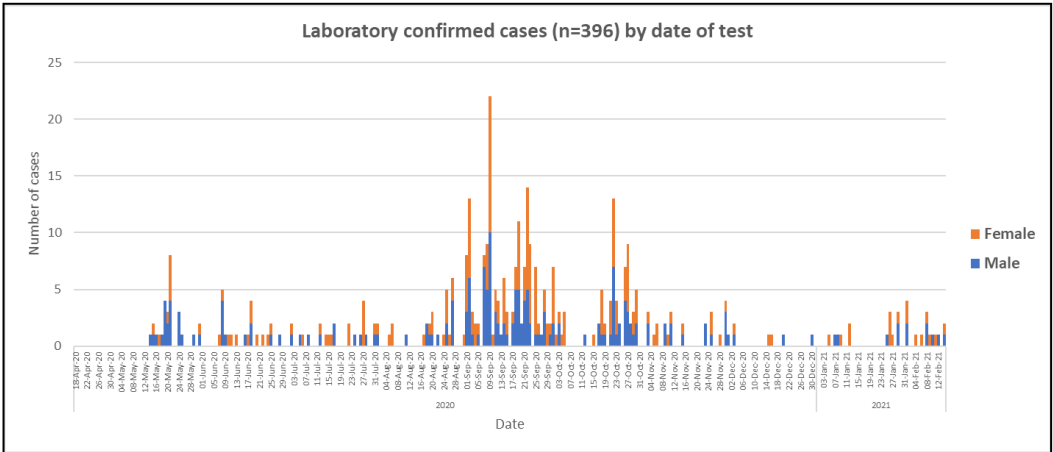


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

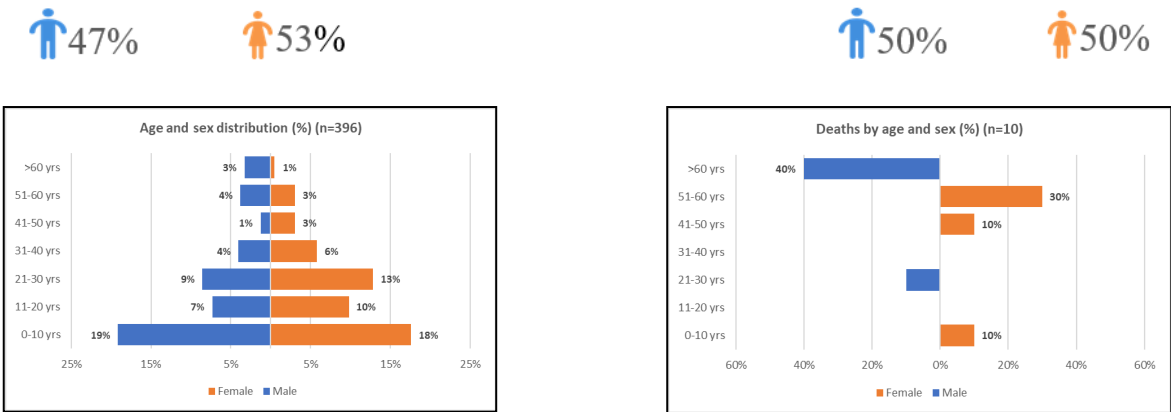


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox’s Bazar

Between weeks 05-06, fifteen new confirmed cases were detected from 1845 samples tested, the test positivity was therefore 0.8%. As of 14 February 2021, the cumulative incidence is 46.1 per 100 000 people. The overall positivity of samples tested is 1.4%. Among the cases, 6.9% showed severe symptoms at the time of admission while 6.4% reported at least one co-morbidity. In total, 10 deaths were reported in the camps due to COVID-19 with a case fatality rate of 2.5%. The median age of tested and confirmed cases was 10 (0-120) & 18 (0-90) years and ratio of females among tested and confirmed cases was 55% and 53% respectively. Though the main age of tested samples was below 10 years, a significant proportion has been tested among 40+ years: 340 per 10 000 population, following that of 0-9 years with 490 tests per 10 000 population as highest number. The test positivity was highest 2% in 30-39 years age cohort followed by 1.7% in 40-49 years and the age specific mortality 0.67 per 10 000 population observed among 40+ years during the period.

A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) has been embedded in the RIRT for COVID-19. A total of 391 confirmed cases (out of 394 to date) have been investigated by Rapid Investigation and Response teams (RIRTs) by 14 February, with contact tracing activities being conducted and captured through Go.data, including the 1498 contacts to be followed up. Out of these, 1279 (85%) contacts have seen their follow up visits completed and were released from quarantine. Thirteen contacts (~1%) became confirmed cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

No Rapid Diagnostic Test (RDT) positive Acute Water Diarrhea (AWD) cases were reported in week 6 (8-14 Feb). The total number of cases reported so far is five in 2021. Out of these, one was culture confirmed and the remaining four tested negative by culture. JAT (Joint Assessment Team) for AWD were activated and assessments took place for each case. In 2020, a total of 28 RDT/Culture positive cases for Cholera were detected through sentinel testing, five of which were confirmed by culture - two from Ukhiya host community, one from Teknaf host community and two from the refugee camps. It is important to note that a cholera outbreak occurred in late 2019 with a reported number of 239 RDT/culture positive cases in response a mass CV vaccination campaign was conducted with over 160 000 children of 1-<5 years having been vaccinated with a 2- doses regimen.

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9222 to date; 3016 in 2017; 5334 in 2018; 617 in 2019; 226 in 2020 and 36 as of week 06 of 2021. In total, 8981 cases were reported in the camps and 241 from the host community with 47 deaths registered in the refugee camps and none in the host community. While the first Diphtheria case was detected on 10 November 2017, the first death occurred on 29 December 2017 and the last death on 25 October 2019. In the last week, eleven (11) agencies involved in contact tracing for Diphtheria cases in the camps met with the objective of reviewing the current activity, achievement, mapping and resources for the reinforcing purposes.

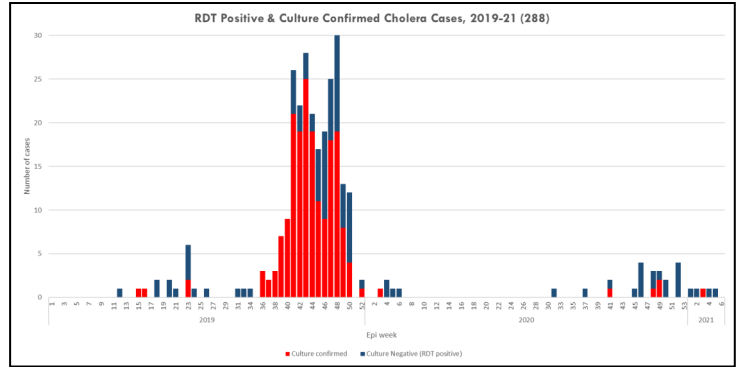


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

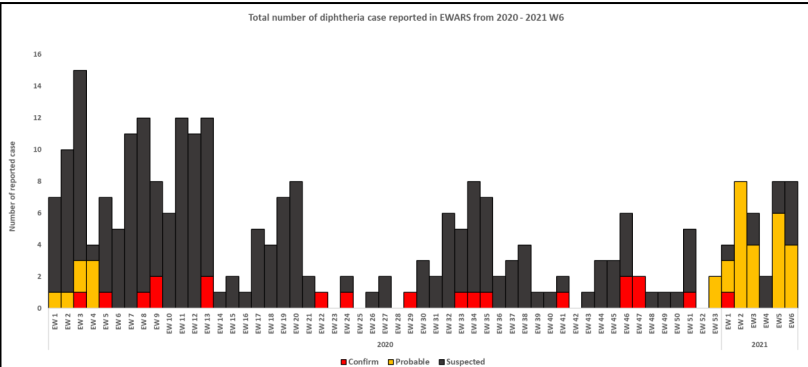


Figure 8: Total number of diphtheria cases reported in EWARS between 2020 (EW4) and 2021.

In week 06 of 2021, a total of three (3) suspected SARI death have been reported. In total 14 deaths have been reported in 2021 of which 10 have been investigated by RIRT for COVID-19 response, the investigation is ongoing for another three (03) while one (01) is pending as it could not be traced. Four (04) deaths have been reclassified as COVID-19 probable death cause. In total 49 suspected SARI deaths were reported in 2020, of these all were verified and 45 underwent investigation. One (01) death was confirmed for COVID-19 and two (2) considered probable. Additionally, nine (09) deaths from COVID-19 confirmed cases were reported with the case fatality rate of 2.7%. Investigation of mortality due to suspected potential infectious causes i.e. SARI, Measles, Cholera, Diphtheria etc. is ongoing in the camps along with death due to maternal causes as high priority.

Revision of Mortality review SoP is in progress including different tools, the overall flow of death notification and subsequent steps in reporting with engaged actors and review processes. Dissemination takes place partially until revision is complete and more updates will be followed shortly by capacity building (in-person) in late February 2021. During the reporting period, one (01) new suspected maternal death has been reported. In total 15 suspected and confirmed maternal/deaths of Women of reproductive age (WRA,12-49 years) have been reported in 2021, of which four (04) deaths have been reported from facilities and directly undergone review by MPMSR (Maternal and Perinatal Mortality Surveillance and Response). In February 2021, a “Training on Mortality Surveillance and Reporting” will be conducted for persons engaged in surveillance and reporting i.e. Medical Team Lead, Medical Doctor, Reporting Officer, SRH Focal Person & CHW Supervisor with the revised protocol for mortality surveillance and further include facility death and death occurred during referral.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

WHO is engaging communities, health partners and other key stakeholders to develop, implement and monitor an action plan to effectively help prepare populations and protect them from COVID-19. Mixed-media messages include general information on COVID-19, hand washing, physical distancing and mask wearing, risks and vulnerabilities, safe and dignified burials, quarantine, isolation, and treatment centres, etc. WHO, through its involvement in the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), continues to coordinate with agencies across the response to ensure that all information around COVID-19 and health issues are of high quality, technically correct and easily understandable by communities. During the reporting period, WHO drafted public health messages on the COVID-19 national vaccination campaign to be disseminated between the Rohingya refugees, the host communities and humanitarian partners. In addition, WHO and UNICEF have also provided English and Bangla versions of the weekly radio script on COVID-19 confirmed cases and number of tests conducted among refugee and host communities and shared with partners to be widely disseminated by the Rohingya community through radio broadcasting. The messages were shared with partners and the COVID-19 update news has been broadcasted through radio partners. Based on the findings of the Informal Health Survey conducted by WHO and UNHCR, appropriate risk communication messages have been drafted for the Rohingya Refugees and shared with UNICEF for feedback. The messages developed focused on encouraging the Rohingya refugees to seek formal health care services provided by the Health Sector partners throughout the camps.

During the reporting period CHWs conducted 306 854 household visits in which 6273 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 36 patients with moderate/severe symptoms. The cumulative number of mild patients is 199 952, and 717 moderate/ severe patients. To date, 44 742 persons with COVID like symptoms were referred to health facilities, 4073 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 584 443 persons between 1-16 February 2021. Since the beginning of the response, CHWs have conducted more than 5.70 million household visits and had contacts with a cumulative number of more than 15.72 million adult household members. Through the CwC WG, another 81 276 people were engaged in 32 800 small group sessions.

WHO continues its support to the Field Laboratory of the Institute of Epidemiology, Disease Control and Research (IEDCR) in the Cox's Bazar Medical College comprising human resources, equipment, supplies/consumables and technical and operational expertise. Between early April 2020 and 14 February 2021, a total of 102 131 tests for COVID-19 have been conducted of which 87 177 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A slight decrease in the number of tests conducted among the Rohingya refugees was observed in weeks 05-06 as compared to weeks 03-04 from 1832 to 1845 tests, as well as in the host community from 3067 in weeks 03-04 to 2971 tests in weeks 05-06. Currently, 26 sample collection sites are operating for suspected COVID-19 patients.

The refurbishment work of the Blood Transfusion units at Ukhiya and Teknaf Health complexes, which were newly established with the support of WHO, has been completed. This is part of the wider effort to increase availability of blood, and lifesaving commodities when dealing with shock due to excess bleeding, obstetric hemorrhages during childbirth and other conditions. WHO carried out a supportive supervision on COVID-19 sample collections procedures and transportation in 20 SARI ITCs and Flu corners in Ukhiya and Teknaf. In addition, WHO conducted several training sessions for seven (07) health care workers working in four (04) health facilities in the camps. The backup power supply of the Institute of Epidemiology, Disease Control and Research (IEDCR) Field Laboratory has been strengthened.

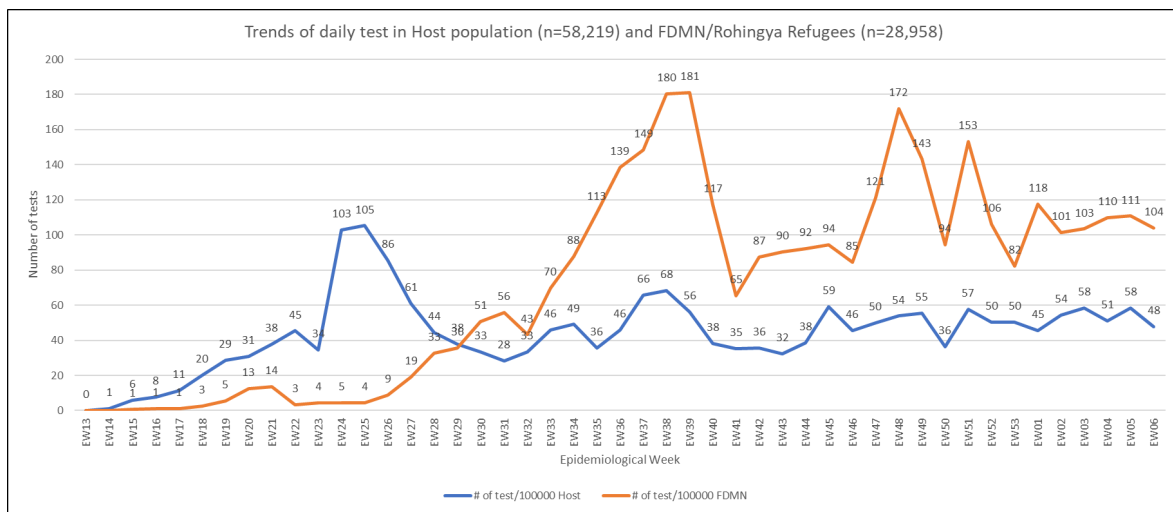


Figure 9: Number of tests conducted per million among the host population and the Rohingya refugees/FDMN

*The Government of Bangladesh refers to Rohingya as "Forcibly Displaced Myanmar Nationals". The UN system refers to this population as Rohingya refugees, in line with the applicable international framework. In this document both terms are used, as appropriate, to refer to the same population.

INFECTION PREVENTION AND CONTROL

To enhance preparedness for COVID-19 in Cox's Bazar, WHO has been training healthcare workers on Infection, Prevention and Control (IPC) from Severe Acute Respiratory Infection (SARI) ITC partners and Government facilities. To date, training for Infection, Prevention and Control (IPC) has been provided to 2390 humanitarian health care workers and government staff from Severe Acute Respiratory Infection (SARI) ITC partners and government facilities.

During the reporting period, the IPC Technical Working Group arranged a meeting on the formation of the District IPC committee for Cox's Bazar with presence of the district leadership such as Civil Surgeon, Principal of the Medical College, Health Coordinator of the RRRC, MoHFCC Medical Coordinator, Head of Department of the Public Health Engineering, District IPC Focal Person, Superintendent DGDA, UHFPO Sadar Upazila, the representative from the Department of Public Health Engineering and delegates from several government agencies, among others. The meeting, which took place on February 3rd, is part of WHO efforts to support the government to institutionalize IPC in the health system in Cox's Bazar envisioning improved patient and healthcare workforce safety.

Supportive supervision was conducted on water sample collection activities at Camp 22 and water sample analysis at the laboratory of the Department of Public Health Engineering (DPHE). A total of 3400 samples were collected and analyzed during the reporting period. WHO WASH and HCWM team observed the activities in accordance with the SoP and relevant technical recommendations were made on sanitary inspection and water sample collection. Community feedback was taken during the visit and the observations were verified and communicated to the WASH sector partners for mitigation. A series of activities are ongoing for the World Bank healthcare waste management (HCWM) project. WHO WASH and HCWM team had a meeting with UNICEF to draft a comprehensive checklist on WASH and HCWM for the healthcare facilities. The document is currently under review and will enhance capacity building among health care workers on WASH and HCWM. In addition, WHO held a meeting with UNDP to integrate the non-hazardous general waste stream into their Solid Waste Management (SWM) project. Several actions for further collaboration and information sharing were agreed upon in order to increase awareness on waste management among the elected local government representatives.

CLINICAL CASE MANAGEMENT

Since the onset of the outbreak, WHO is coordinating regular weekly specialist Operational, Clinical and Critical care online forums; each with a multidisciplinary panel of health care providers with experience in the clinical management of patients with COVID-19 and other viral infections to foster peer to peer support and knowledge exchange. With the guidance provided by WHO experts, the initiative is serving as a foundation for optimized clinical care to ensure the best possible chance for survival of patients in Cox's Bazar. During the reporting period, one (01) working group meeting along with two (02) case conferences for SARI ITCs and two (02) case conferences for ICU were conducted. As of 16 February, there are 13 operational SARI ITCs in the camps with a total of 502 functional beds open and 415 on stand by. The SARI ITC bed occupancy is currently 87. At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 8 beds and the Severe Care Unit (SCU) 20 beds functional beds. At the moment, 14 beds are occupied in total.

ESSENTIAL HEALTH SERVICES

Ensuring the provision of essential health services remains a priority in Cox's Bazar. Under the coordination of WHO and the Civil Surgeon, Cox's Bazar, the Health Sector is providing health care to nearly 890 000 Rohingya refugees and 472 000 Bangladeshi living in the surrounding areas of the refugee camps. The health facilities run by Health Sector partners to provide services to the population include 38 primary health care centres (PHCs), 97 Health Posts (HPs), 23 special facilities and three field hospitals.

WHO, in collaboration with UNHCR, organized two training courses on mhGAP and stress module for primary health care services (27 doctors and 39 nurses) working at the Intensive Care Unit (ICU) and High Dependency Unit (HDU) at Sadar Hospital in Cox's Bazar. The training helped these healthcare professionals who often handle high-pressure situations to better cope with the stress and to improve their psychosocial support to the beneficiaries. In addition, WHO carried out supportive supervision sessions at Ukhiya and Teknaf to help staff trained on mhGAP better integrate mental health services and psychosocial support in primary health care services. Further trainings on mhGAP are scheduled for the upcoming weeks with the aim of reaching at least one trained clinician in each of the public health care facilities in the camps. WHO and MoHFWCC conducted supportive supervision visits on the implementation of national guideline for Non-Communicable Diseases in 11 World Bank supported health facilities at Ukhiya Upazila. The facilities included community clinics, union sub centers, Upazila Health Complex, health posts and primary health care centers across the Rohingya camps. Through these visits, health care staffs were oriented on different technical aspects of NCD service implementation, distribution of job aids, and discussions on facility level challenges with provision of NCD care. Joint recommendations were developed for the 1st quarter of 2021 to improve NCD service delivery.

Routine immunization (RI) sessions continue, both fixed and outreach, with WHO's guidance on the operation and sustaining of immunization programs during the COVID-19 pandemic, and a revised strategy and micro-plan having been reviewed by Government with technical assistance from WHO and other partners based on data collected in 2020. Since February 2021, the new revised micro plan has been implemented in the camps. Outreach sessions are going to be conducted in 2 ways - Community based, and Health facility based. Coverage gaps in the blocks/ sub-blocks were identified based on the data. Session monitoring and House to house monitoring of RI continues to be ensured by IVD teams. Vaccine-Preventable Disease surveillance is being closely monitored by government authorities with WHO's technical support. WHO teams continue to visit health facilities for surveillance, monitoring and investigation to contribute to the National Acute Flaccid Paralysis (AFP) & VPD surveillance system.



Photo: IOM MHPSS Officer, Dr Kurdvim Rasool, and WHO MHPSS Officer, Dr Mushfique Mahmud conducting a mhGAP training at camp 24 Leda, in Teknaf

MONSOON AND CYCLONE PREPAREDNESS

The Health Sector, with respective working groups and partners regularly updates its contingency plan for cyclone (March-June) and monsoon (September-November) seasons. Information related to health facility functionality, contingency supplies and locations, mobile medical teams (MMT), ambulance network systems to respond to emergencies and list of camp health focal points is maintained and updated regularly. During the reporting period, WHO and IOM, as co-chairs to the Emergency Preparedness and Response Working Group, shared the pre-final version of the Health Sector Preparedness and Response Plan to Monsoon and Cyclone with Health Sector partners for their feedback. This updated plan is currently in the final reviewing stage.

WHO continues to ensure timely provision of quality and adequate supplies, equipment and consumables for the health emergency operations in Cox's Bazar. During the reporting period, a total of 3034.9.17 Kg and 23.47 Cubic meters of Medicines were deployed to Cox's Bazar including Viral Transport Medium (VTMs) for the diagnosis of COVID-19. WHO received 8735.50 Kg of medicines, kits for gap filling, PPE and oxygen generator. WHO continues its support to the sample collection in the camps with two vehicles and is supporting the refurbishment work for the IEDCR Field Lab expansion in the Cox's Bazar Medical College.

POINTS OF ENTRY

The 12 existing points of entry (PoE) are currently functional in different strategic locations around the camps. A total of 75 722 individuals have been screened during the reporting period. Staff continue to support the identification of febrile passengers and pedestrians whilst providing hygiene education related to COVID-19 health awareness and referring patients to nearby health facilities for medical assessment when having fever.

SUBJECT IN FOCUS: Facilitating equitable access to safe and effective COVID-19 vaccines - the inclusion of the Rohingya refugees in the Bangladesh COVID-19 national vaccination plan.

As a result of the remarkable international cooperation and the urgency generated by the pandemic that has soared around the world, in less than a year vaccines against COVID-19 have become the fastest ever to be developed, tested and approved. After a long battle against the coronavirus, the vaccine has brought a glimpse of hope for 2021. In Cox's Bazar, Bangladesh, the Rohingya refugee population has just been included in the national vaccination plan for COVID-19.



Photo: WHO IVD Team Lead, Dr. Md. Zion and the national consultant for COVID-19 vaccination Dr. Tazkia Tarannum have been providing technical support for the rolling out of the COVID-19 vaccination campaign in Cox's Bazar

Context

WHO has just listed two versions of the AstraZeneca/Oxford COVID-19 vaccine for emergency use, giving the green light for these vaccines to be rolled out globally through COVAX. In the case of the two AstraZeneca/Oxford vaccines, produced by AstraZeneca-SKBio (Republic of Korea) and the Serum Institute of India, WHO assessed the quality, safety and efficacy data, risk management plans and programmatic suitability, such as cold chain requirements. The process took under four weeks. This is also the vaccine which is currently available in Bangladesh.

WHO's Emergency Use Listing (EUL) assesses the quality, safety and efficacy of COVID-19 vaccines and is a prerequisite for COVAX Facility vaccine supply. It also allows countries to expedite their own regulatory approval to import and administer COVID-19 vaccines. Once vaccines are demonstrated to be safe and efficacious, they must be approved by national regulators,

manufactured to exacting standards, and distributed. WHO is working with partners around the world to help coordinate key steps in this process, including to facilitate equitable access to safe and effective COVID-19 vaccines for the billions of people who will need them.

National Deployment and Vaccination Plan for COVID-19 vaccines in Bangladesh

In Bangladesh, the preparations for the COVID-19 vaccination campaign have started months ago through technical discussions and coordination meetings between senior authorities of the Government of Bangladesh (GoB) and key health partners to jointly prepare for, coordinate and effectively implement the COVID-19 national vaccination campaign.

In Cox's Bazar, the inclusion of Rohingya refugees in the COVID-19 national vaccination plan started as early as October 2020 when the COVID-19 Vaccine Preparedness and Deployment Core Committee was established in the district, to facilitate the equitable access to safe and effective COVID-19 vaccines for all.

Under the leadership of the Government of Bangladesh (GoB), the WHO Immunization and Vaccine Development (IVD) team, together with all humanitarian organizations responding to the Rohingya crisis, initiated a draft proposal and budget to include the refugee population in the National Deployment and Vaccination Plan for COVID-19 Vaccines (NDVP). As a result, in the span of a week a proposal was shared for review. Throughout the month of November, several preparatory meetings were held to categorize vaccine recipients and define priorities

in the world's largest refugee camp and on December 8th a workshop on COVID-19 vaccination was organized, to further discuss the proposed plan with government authorities and relevant partners and stakeholders.



Photo: WHO Head of Sub-Office, Dr Kai von Harbou, at the opening ceremony for the COVID-19 vaccination campaign at the 250 Bed Sadar District Hospital in Cox's Bazar

countries and vulnerable populations such as the Cox's Bazar Rohingya refugees can stand a chance against the coronavirus pandemic. As such, the inclusion of the refugee population in the Bangladesh COVID-19 National Vaccination Plan has been one of the Health Sector's priorities for Cox's Bazar. On February 6th 2021, a revised version of the National Deployment and Vaccination Plan for COVID-19 (NDVP) was signed by the Government of Bangladesh including the Rohingya refugee population as a target group. Based on epidemiological surveillance data, prioritization will be given to older age groups (>40 years) for Rohingya refugees, Rohingya frontline health workers, volunteers, teachers and others will be prioritized in the first phase of the vaccination campaign in the camps.

The WHO Immunization and Vaccine Development (IVD) team is working on the details of planning and budgeting documents as part of a consultative process with the Civil Surgeon, the community clinic of the Ministry of Health and Family Welfare (MoHFW-CC), the Refugee Relief and Repatriation Commissioner (RRRC) and key development partners such as UNICEF and UNHCR. Aspects such as transport and storage of vaccines, geographical distribution and facility-based vaccination with support from vaccination teams are currently being planned. The Inclusion of the Rohingya refugee in the NDVP Vaccination plan of Rohingya refugees will follow the same criteria as the vaccination programme for Bangladeshi nationals. Health and equity principles will apply under the supervision of the National Immunisation Technical Advisory Group (NITAG) and WHO's strategic advisory group of experts on immunisation (SAGE).

The Government of Bangladesh has also set up a COVID-19 Vaccination Cell at the Directorate General of Health Services (DGHS). This cell helps to coordinate and support the deployment of COVID-19 vaccines at national and sub-national levels, which comprise Cox's Bazar, Ukhiya and Teknaf districts, including the Rohingya refugee population. To ensure vaccine safety and regulatory preparedness, the Government of Bangladesh has engaged the Directorate General of Drug Administration (DGDA). Furthermore, a risk management plan (RMP) is in place to safeguard any secondary effects associated with the COVID-19 vaccine. Also, a Risk communication and Community Engagement (RCCE) team has been dedicated to develop a crisis communication plan.

Training

Following early discussions regarding the vaccination planning, several trainings were organized by the government with WHO's technical support to ensure effective vaccine management including the registration process, ensuring vaccine quality, injection techniques, how to preserve the vials, possible adverse effects, among others. Some 40 participants benefited from this training including relevant Government officials from Upazila Health and Family Planning Officers (UH&FPO), doctors, nurses, MT-EPIs and others.

Cox's Bazar Humanitarian Workers

Based on the NVDP, national and international staff serving in the Rohingya humanitarian crisis will also be considered in the COVID-19 vaccination campaign. Both national and international humanitarian frontline workers can already register in the COVID-19 vaccine registration app "Surokkha" developed by the Government for the line listing of COVID-19 vaccine. To date, around 15 000 workers from approximately 100 organizations applied for the vaccine, the list has been sent to the Civil Surgeon office by the Health Sector. There are

Rolling out the COVID-19 National Vaccination Campaign

Bangladesh has started rolling out its COVID-19 National Vaccination Programme on February 7th, 2021, comprising 46 vaccination centres in the capital and around 1000 across the country. In only one week the vaccine reached over 900 000 people and more are planned to be vaccinated throughout 2021. As of 16 February 2021, some 28 537 people received the first doses of the COVID-19 vaccine in Cox's Bazar and nationwide the number reached up to 1 359 613 to date. In Cox's Bazar, District Sadar Hospital received 16 840 doses, Teknaf Upazila received 9698 and Ukhiya Upazila 7607.

Including the refugee population in the COVID-19 National Vaccination Plan

The equitable access to safe and effective COVID-19 vaccines is part of WHO's priorities for 2021 to make sure that poorer



Photo: At the AEFI (Adverse Event Following Immunization) room, doctors and nurses stood ready in case any patient would experience any adverse effect after vaccination.

three categories concerning Humanitarian Workers Prioritization for the COVID-19 vaccine in Cox's Bazar:

Category A: All health care workers working in healthcare facilities (including support staff) in the Rohingya Camps.

Category B: Humanitarian workers who work in the camps >50% of the time (e.g. site management, protection, education/learning centres, nutrition, food, WASH etc.) excluding those under Category A.

Category C: Any humanitarian staff, regardless of work location, who are not included in Categories A or B.

Equitable distribution is particularly important in the area of vaccines, which, if used correctly and equitably, could help to stop the acute phase of the pandemic and allow the rebuilding of our societies and economies. The world has united in the fight against COVID-19 and we must continue to work together until everyone is protected and safe.



Photo: Frontline healthcare workers have been some of the most at risk groups during the pandemic. As such, many have taken their first doses in Cox's Bazar

NATIONAL LEVEL HIGHLIGHTS, 16 February 2021 (BANGLADESH)

	Last 24 hours	Total
COVID-19 tests conducted	14 788	3 877 042
COVID-19 positive cases	446	541 038
Number of people released/recovered	641	487 870
COVID-19 deaths	11	8 285

WHO global situation report: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>

WHO interim guideline on Preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings: [https://www.who.int/publications-detail/preparedness-prevention-and-control-of-coronavirus-disease-\(covid-19\)-for-refugees-and-migrants-in-non-camp-settings](https://www.who.int/publications-detail/preparedness-prevention-and-control-of-coronavirus-disease-(covid-19)-for-refugees-and-migrants-in-non-camp-settings)

Institute of Epidemiology, Disease Control and Research (IEDCR) for COVID-19 updates in Bangladesh : <https://www.iedcr.gov.bd/>
COVID-19 Bangladesh situation reports: [https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update/coronavirus-disease-\(covid-19\)-bangladesh-situation-reports](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/coronavirus-disease-(covid-19)-bangladesh-situation-reports)

WHO Bangladesh awareness and risk communication materials in Bengali: [https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update)

Previous issues of this Situation Report: <https://www.who.int/bangladesh/emergencies/Rohingyacrisis/bulletin-and-reports>

COVID-19 Dashboard under WHO Cox's Bazar Data Hub can be accessed here: <https://cxb-epi.netlify.app/>

Write to coord_cxb@who.int to receive COVID-19 updates and situation reports from Cox's Bazar with the subject "Add me to the situation reports and updates mailing list"



CONTACTS

Dr Bardan Jung RANA
WHO Representative
WHO Bangladesh
Email: ranab@who.int

Dr Kai VON HARBOU
Head of Sub-Office
WHO CXB Sub-Office
Email: vonharbouk@who.int